

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service
Statutory Service	Adult Day Care
Statutory Service	Case Management
Statutory Service	Consumer Directed Attendant Care - Skilled
Statutory Service	Prevocational Services
Statutory Service	Respite
Statutory Service	Supported Employment
Extended State Plan Service	Specialized Medical Equipment
Supports for Participant Direction	Financial Management Service - Supports the self-direction option
Other Service	Behavioral Programming
Other Service	Consumer Directed Attendant Care (CDAC) unskilled
Other Service	Family Counseling and Training Services
Other Service	Home and Vehicle Modification
Other Service	Independent Support Broker - Consumer Choices Option
Other Service	Interim Medical Monitoring and Treatment (IMMT)
Other Service	Personal Emergency Response System or Portable Locator System
Other Service	Self Directed Community Support and Employment
Other Service	Self Directed Goods and Services
Other Service	Self Directed Personal Care - Consumer Choices Option
Other Service	Supported Community Living
Other Service	Transportation

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on regular or intermittent basis in a day care center. Meals provided as part of these services shall not constitute a full nutritional day. These services are contracted through the individual county where the provider operates.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Adult day services has an upper rate limit if there is no Veterans Administration contract. The upper rate limits are pursued in 441 IAC Chapter 79. The rates are subject to change on a yearly basis. A unit of service is 15 minutes, a half day (1 to 4 hours), a full day (4.25 to 8 hours) or an extended day (8.25 to 12 hours). Transportation is not a required element of adult day services but if the cost of transportation is provided and charged to Medicaid, the cost of transportation must be included in the adult day health rate. The case manager is responsible for authorizing services based on member need and monitors the service to assure that needed services are provided. If transportation to and from the ADC is needed (based on the ADC providers transportation), the CM will authorize and monitor the authorized transportation as needed.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☒ Legally Responsible Person
☒ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Agencies that are certified by the Department of Inspections and Appeals

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Adult Day Care

Provider Category:Agency ☒**Provider Type:**

Adult Day Care Agencies that are certified by the Department of Inspections and Appeals

Provider Qualifications

License (specify):

Certificate (specify):

Agency that is certified by the Department of Inspection and Appeals as being in compliance with the standards for adult day services located at 481 Iowa Administrative Code - Chapter 70.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Providers are recertified every four years

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ✓

Service:

Case Management ✓

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:**

01 Case Management ✓

Sub-Category 1:

01010 case management ✓

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Covered services. The following shall be included in the assistance that case managers provide to members in obtaining services:

- a. Assessment. The case manager shall perform a comprehensive assessment and periodic reassessment of the member's individual needs using Form 470-4694, Targeted Case Management Comprehensive Assessment, to determine the need for any medical, social, educational, housing, transportation, vocational or other services. The comprehensive assessment shall address all of the member's areas of need, strengths, preferences, and risk factors, considering the member's physical and social environment. A face-to-face reassessment must be conducted at a minimum annually and more frequently if changes occur in the member's condition. The assessment and reassessment activities include the following:
 - (1) Taking the member's history, including current and past information and social history in accordance with 441—subrule 24.4(2), and updating the history annually.
 - (2) Identifying the needs of the member and completing related documentation.
 - (3) Gathering information from other sources, such as family members, medical providers, social workers, legally authorized representatives, and others as necessary to form a complete assessment of the member.
- b. Service plan. The case manager shall develop and periodically revise a comprehensive service plan based on the comprehensive assessment, which shall include a crisis intervention plan based on the risk factors identified in the risk assessment portion of the comprehensive assessment. The case manager shall ensure the active participation of the member and work with the member or the member's legally authorized representative and other sources to choose providers and develop the goals. This plan shall:
 - (1) Document the parties participating in the development of the plan.
 - (2) Specify the goals and actions to address the medical, social, educational, housing, transportation, vocational or other services needed by the member.
 - (3) Identify a course of action to respond to the member's assessed needs, including identification of all providers, services to be provided, and time frames for services.
 - (4) Document services identified to meet the needs of the member which the member declined to receive.
 - (5) Include an individualized crisis intervention plan that identifies the supports available to the member in an emergency. A crisis intervention plan shall identify:
 1. Any health and safety issues applicable to the individual member based on the risk factors identified in the member's comprehensive assessment.
 2. An emergency backup support and crisis response system, including emergency backup staff designated by providers, to address problems or issues arising when support services are interrupted or delayed or the member's needs change. The interdisciplinary team shall determine which of the following options will be included in the crisis intervention plan:
 - After-hours contact information for all persons or resources identified for the member and an alternate contact to be used in the event that an individual provider not employed by an agency is not present to provide services as scheduled; or
 - After-hours contact information for an on-call system for the provider of case management to ensure that in the event of an emergency, members have access to a case manager 24 hours per day, including weekends and holidays.

(6) Include a discharge plan.

(7) Be revised at least annually and more frequently if significant changes occur in the member's medical, social, educational, housing, transportation, vocational or other service needs or risk factors.

c. Referral and related activities. The case manager shall perform activities to help the member obtain needed services, such as scheduling appointments for the member, and activities that help link the member with medical, social, educational, housing, transportation, vocational or other service providers or programs that are capable of providing needed services to address identified needs and risk factors and to achieve goals specified in the service plan.

d. Monitoring and follow-up. The case manager shall perform activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the service plan is effectively implemented and adequately addresses the needs of the member. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home when applicable), and all services. Monitoring may also include review of service provider documentation.

Monitoring shall be conducted to determine whether:

(1) Services are being furnished in accordance with the member's service plan, including the amount of service provided and the member's attendance and participation in the service.

(2) The member has declined services in the service plan.

(3) Communication is occurring among all providers to ensure coordination of services.

(4) Services in the service plan are adequate, including the member's progress toward achieving the goals and actions determined in the service plan.

(5) There are changes in the needs or status of the member. Follow-up activities shall include making necessary adjustments in the service plan and service arrangements with providers.

e. Contacts. Case management contacts shall occur as frequently as necessary and shall be conducted and documented as follows:

(1) The case manager shall have at least one face-to-face contact with the member every three months.

(2) The case manager shall have at least one contact per month with the member, the member's legally authorized representative, the member's family, service providers, or other entities or individuals.

This contact may be face-to-face or by telephone. The contact may also be by written communication, including letters, E-mail, and fax, when the written communication directly pertains to the needs of the member. E-mail contacts are allowed only when other means of communication are not feasible for the member, representative or family and the necessity for E-mail communication is documented in the member's comprehensive service plan. A copy of any written communication must be maintained in the case file. When E-mail communication is used, there must be clear two-way communication in the member's record showing an exchange of information, as well as follow-up activity related to the information.

(3) The case manager may bill for contacts with non-eligible persons if the contacts are directly related to identifying the member's needs and care as necessary for the purpose of helping the member access services, identifying needs and supports to assist the member in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the member's needs.

(4) When applicable, documentation of case management contacts shall include:

1. The name of the service provider.

2. The need for and occurrences of coordination with other case managers within the same agency or of referral or transition to another case management agency.

90.5(2) Exclusions.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Payment for case management may not be made until the member is enrolled in the waiver. Payment can also only be made if case management activity is performed on behalf of the member during the month. Case Managers are required to have at least quarterly face to face contacts. Payment shall not be made for activities otherwise within the definition of case management when any of the following conditions exist:

a. The activities are an integral component of another covered Medicaid service, including but not limited to assertive community treatment (ACT).

b. The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred. Such services include, but are not limited to:

(1) Services under parole and probation programs.

(2) Public guardianship programs.

(3) Special education programs.

(4) Child welfare and child protective services.

(5) Foster care programs.

c. The activities are integral to the administration of foster care programs, including but not limited to the following:

(1) Research gathering and completion of documentation required by the foster care program.

(2) Assessing adoption placements.

(3) Recruiting or interviewing potential foster care parents.

(4) Serving legal papers.

(5) Home investigations.

(6) Providing transportation.

(7) Administering foster care subsidies.

(8) Making placement arrangements.

d. The activities for which a member may be eligible are integral to the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case

management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act.

e. The activities duplicate institutional discharge planning.

Transition to a community setting. Case management services may be provided to a member transitioning to a community setting during the 60 days before the member's discharge from a medical institution when the following requirements are met:

a. The member is an adult who qualifies for targeted case management under a targeted population. Transitional case management services are not available under the Brain Injury waiver, but are provided as a State Plan service to Brain Injury waiver members for 30 days prior to discharge to coordinate discharge planning, this services may not duplicate the efforts of the facility's discharge planner

b. Case management services shall be coordinated with institutional discharge planning, but shall not duplicate institutional discharge planning

A unit of service is one 15 minute increment. .

Service Delivery Method (check each that applies):

☐ Participant-directed as specified in Appendix E

☒ Provider managed

Specify whether the service may be provided by (check each that applies):

☐ Legally Responsible Person

☐ Relative

☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency - DHS
Agency	Agency- County
Agency	Agency - Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency ☒

Provider Type:

Agency - DHS

Provider Qualifications

License (specify):

Certificate (specify):

An Agency that meets Iowa Administrative code 441.24 for case management services. The Agency submits their certification papers along with their provider application in order to be enrolled to provide case management

An Agency or individual that is accredited through the Commission on Accreditation of Rehabilitation Facilities for Case Management services. They must attach a current certification and most recent CARF survey report

Other Standard (specify):

Qualified case managers and supervisors" means people who have the following qualifications:

1. A bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to the population groups that the person is hired as a case manager or case management supervisor to serve; or

2. An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.

j Case management services. "Case management services" means those services established pursuant to Iowa Code section 225C.20.

a. Performance benchmark. Case management services link individuals using the service to

service agencies and support systems responsible for providing the necessary direct service activities and coordinate and monitor those services.

b. Performance indicators.

(1) Staff clearly define the need for case management and document it annually.

(2) At a minimum, the team is composed of the individual using the service, the case manager, and providers or natural supports relevant to the individual's service needs. The team may also include family members, at the discretion of the individual using the service.

(3) The team works with the individual using the service to establish the service plan that guides and coordinates the delivery of the services.

(4) The case manager advocates for the individual using the service.

(5) The case manager coordinates and monitors the services provided to the individual using the service.

(6) Documentation of contacts includes the date, the name of the individual using the service, the name of the case manager, and the place of service.

(7) The case manager holds individual face-to-face meetings at least quarterly with the individual using the service.

(8) Case managers do not provide direct services. Individuals using the service are linked to appropriate resources, which provide necessary direct services and natural supports.

(9) Individuals using the service participate in developing an individualized crisis intervention plan that includes natural supports and self-help methods.

(10) Documentation shows that individuals using the service are informed about their choice of providers as provided in the county management plan.

(11) Within an accredited case management program, the average caseload is no more than 45 individuals per each full-time case manager. The average caseload of children with serious emotional disturbance is no more than 15 children per full-time case manager.

(12) The case manager communicates with the team and then documents in the individual's file a quarterly review of the individual's progress toward achieving the goals.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Providers are recertified every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency ☒

Provider Type:

Agency- County

Provider Qualifications

License (specify):

Certificate (specify):

An Agency that meets Iowa Administrative code 441.24 for case management services. The Agency submits their certification papers along with their provider application in order to be enrolled to provide case management

An Agency that is accredited through the Commission on Accreditation of Rehabilitation Facilities for Case Management services. They must attach a current certification and most recent CARF survey report.

Other Standard (specify):

Qualified case managers and supervisors" means people who have the following qualifications:

1. A bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to the population groups that the person is hired as a case manager or case management supervisor to serve; or

2. An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.

) Case management services. "Case management services" means those services established

pursuant to Iowa Code section 225C.26.

a. Performance benchmark. Case management services link individuals using the service to service agencies and support systems responsible for providing the necessary direct service activities and coordinate and monitor those services.

b. Performance indicators.

(1) Staff clearly define the need for case management and document it annually.

(2) At a minimum, the team is composed of the individual using the service, the case manager, and providers or natural supports relevant to the individual's service needs. The team may also include family members, at the discretion of the individual using the service.

(3) The team works with the individual using the service to establish the service plan that guides and coordinates the delivery of the services.

(4) The case manager advocates for the individual using the service.

(5) The case manager coordinates and monitors the services provided to the individual using the service.

(6) Documentation of contacts includes the date, the name of the individual using the service, the name of the case manager, and the place of service.

(7) The case manager holds individual face-to-face meetings at least quarterly with the individual using the service.

(8) Case managers do not provide direct services. Individuals using the service are linked to appropriate resources, which provide necessary direct services and natural supports.

(9) Individuals using the service participate in developing an individualized crisis intervention plan that includes natural supports and self-help methods.

(10) Documentation shows that individuals using the service are informed about their choice of providers as provided in the county management plan.

(11) Within an accredited case management program, the average caseload is no more than 45 individuals per each full-time case manager. The average caseload of children with serious emotional disturbance is no more than 15 children per full-time case manager.

(12) The case manager communicates with the team and then documents in the individual's file a quarterly review of the individual's progress toward achieving the goals.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Providers are recertified every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency ☒

Provider Type:

Agency - Provider

Provider Qualifications

License (specify):

An Agency that meets Iowa Administrative code 441.24 for case management services. The Agency submits their certification papers along with their provider application in order to be enrolled to provide case management.

An Agency that is accredited through the Commission on Accreditation of Rehabilitation Facilities for Case Management services. They must attach a current certification and most recent CARF survey report.

Certificate (specify):

Other Standard (specify):

"Qualified case managers and supervisors" means people who have the following qualifications:

1. A bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to the population groups that the person is hired as a case manager or case management supervisor to serve; or

2. An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.

1 Case management services. "Case management services" means those services established pursuant to Iowa Code section 225C.20.

a. Performance benchmark. Case management services link individuals using the service to service agencies and support systems responsible for providing the necessary direct service activities and coordinate and monitor those services.

b. Performance indicators.

(1) Staff clearly define the need for case management and document it annually.

(2) At a minimum, the team is composed of the individual using the service, the case manager, and providers or natural supports relevant to the individual's service needs. The team may also include family members, at the discretion of the individual using the service.

(3) The team works with the individual using the service to establish the service plan that guides and coordinates the delivery of the services.

(4) The case manager advocates for the individual using the service.

(5) The case manager coordinates and monitors the services provided to the individual using the service.

(6) Documentation of contacts includes the date, the name of the individual using the service, the name of the case manager, and the place of service.

(7) The case manager holds individual face-to-face meetings at least quarterly with the individual using the service.

(8) Case managers do not provide direct services. Individuals using the service are linked to appropriate resources, which provide necessary direct services and natural supports.

(9) Individuals using the service participate in developing an individualized crisis intervention plan that includes natural supports and self-help methods.

(10) Documentation shows that individuals using the service are informed about their choice of providers as provided in the county management plan.

(11) Within an accredited case management program, the average caseload is no more than 45 individuals per each full-time case manager. The average caseload of children with serious emotional disturbance is no more than 15 children per full-time case manager.

(12) The case manager communicates with the team and then documents in the individual's file a quarterly review of the individual's progress toward achieving the goals.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services- Iowa Medicaid Enterprise

Frequency of Verification:

Providers are recertified every four years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ☒

Service:

Personal Care ☒

Alternate Service Title (if any):

Consumer Directed Attendant Care - Skilled

HCBS Taxonomy:

Category 1:

08 Home-Based Services ☒

Sub-Category 1:

08030 personal care ☒

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Skilled consumer-directed attendant care services shall be provided by the CDAC provider under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

Skilled Consumer Directed Attendant Care service activities may include helping the member with any of the following skilled

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.
- (8) Colostomy care.
- (9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is 15 minutes provided by an individual or an agency.

Each service shall be billed in whole units.

CDAC may be provided to a recipient of in-home health related care services, but not at the same time. There is an upper limit for both agency and individual providers. These are subject to change on a yearly basis.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

These services may not duplicate services provided under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☒ Legally Responsible Person
- ☒ Relative
- ☒ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Chore Provider
Agency	Adult Day Service provider
Agency	Home Care provider
Agency	Community Action Agency
Agency	Supported Community Living provider

Provider Category	Provider Type Title
Agency	Assisted Living Program
Agency	Home Health Agency
Individual	Individual


Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency 

Provider Type:

Chore Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging. Providers must be:

1. At least 18 years of age, and
2. Qualified or trained to carry out the member's plan of care pursuant to the department's approved plan.
3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
5. All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. A provider may be disenrolled if an individual is convicted of any criminal activity or has a founded abuse record.

For this service the department the specific standards for subcontracts or providers regarding training, age limitations, experience or education are indicated above. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case Managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care providers must be at least 18 years of age.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service


Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled
Provider Category:
Agency <input checked="" type="checkbox"/>
Provider Type:
Adult Day Service provider
Provider Qualifications
License (specify):
Certificate (specify):
The Adult Day Care Provider standards are contained in the Department of Inspections and Appeals administrative rules at 481 Iowa Administrative Code Chapters 67 and 79.
Other Standard (specify):
Initial certification process for a nonaccredited program.
(1) Upon receipt of all completed documentation, including state fire marshal approval and structural and evacuation review approval, the department of inspections and appeals (DIA) shall determine whether the proposed program meets applicable requirements.
(2) If, based upon the review of the complete application, including all required supporting documents, the department determines the proposed program meets the requirements for certification, a provisional certification shall be issued to the program to begin operation and accept participants.
(3) Within 180 calendar days following issuance of provisional certification, the department shall conduct a monitoring to determine the program's compliance with applicable requirements.
(4) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10 (17A.231B, 231C, 231D) shall be followed.
(5) The department shall make a final certification decision based on the results of the monitoring and review of an acceptable plan of correction.
(6) The department of inspections and appeals (DIA) shall notify the program of a final certification decision within 10 working days following the finalization of the monitoring report or receipt of an acceptable plan of correction, whichever is applicable.
70.5(7) If the decision is to continue certification, the department shall issue a full two-year certification effective from the date of the original provisional certification.
Certification or recertification of an accredited program—application process.
70.9(1) An applicant for certification or recertification of a program accredited by a recognized accrediting entity shall:
a. Submit a completed application packet obtained from the department.
Application materials may be obtained from the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home.do ; by mail from the Department of Inspections and Appeals, Adult Services Bureau, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083; or by telephone at (515)281-6325.
b. Submit a copy of the current accreditation outcome from the recognized accrediting entity.
c. Apply for certification or recertification within 90 calendar days following verification of compliance with life safety requirements pursuant to this chapter.
d. Maintain compliance with life safety requirements pursuant to this chapter.
e. Submit the appropriate fees as set forth in Iowa Code section 231D.4.
(2) The department shall not consider an application until it is complete and includes all supporting documentation and the appropriate fees
Recognized accrediting entity.
(1) The department designates CARF as a recognized accrediting entity for programs.
(2) To apply for designation by the department of inspections and appeals (DIA) as a recognized accrediting entity for programs, an accrediting entity shall submit a letter of request, and its standards shall, at minimum, meet the applicable requirements for programs.
(3) The designation shall remain in effect for as long as the accreditation standards continue to meet, at minimum, the applicable requirements for programs.
(4) An accrediting entity shall provide annually to the department, at no cost, a current edition of the applicable standards manual and survey preparation guide, and training thereon, within 120 working days after the publications are released.
Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type:** Statutory Service**Service Name:** Consumer Directed Attendant Care - Skilled**Provider Category:**Agency **Provider Type:**

Home Care provider

Provider Qualifications*License (specify):**Certificate (specify):*

Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—Iowa Administrative Code 80.5(135), 80.6(135), and 80.7(135).

Other Standard (specify):

The authorized agency shall ensure that each individual assigned to perform home care aide services meets one of the following:

- (1) Be an individual who has completed orientation to home care in accordance with agency policy. At a minimum, orientation shall include four hours on the role of the home care aide; two hours on communication; two hours on understanding basic human needs; two hours on maintaining a healthy environment; two hours on infection control in the home; and one hour on emergency procedures. The individual shall have successfully passed an agency written test and demonstrated the ability to perform skills for the assigned tasks; or
 - (2) Be an individual who is in the process of receiving education or has completed the educational requirements but is not licensed as an LPN or RN, has documentation of successful completion of coursework related to the tasks to be assigned, and has demonstrated the ability to perform the skills for the assigned tasks; or
 - (3) Be an individual who possesses a license to practice nursing as an LPN or RN in the state of Iowa; or
 - (4) Be an individual who is in the process of receiving education or who possesses a degree in social work, sociology, family and consumer science, education, or other health and human services field; has documentation of successful completion of coursework related to the tasks to be assigned; and has demonstrated the ability to perform the skills for the assigned tasks.
- b. The authorized agency shall ensure that services or tasks assigned are appropriate to the individual's prior education and training.
- c. The authorized agency shall ensure documentation of each home care aide's completion of at least 12 hours of annual in-service (prorated to employment).
- d. The authorized agency shall establish policies for supervision of home care aides.
- e. The authorized agency shall maintain records for each consumer. The records shall include:
- (1) An initial assessment;
 - (2) A plan of care;
 - (3) Assignment of home care aide;
 - (4) Assignment of tasks;
 - (5) Reassessment;
 - (6) An update of the plan of care;
 - (7) Home care aide documentation; and
 - (8) Documentation of supervision of home care aides.

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in

direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care providers must be at least 18 years of age.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency ☒

Provider Type:

Community Action Agency

Provider Qualifications

License (specify):

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Certificate (specify):

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Other Standard (specify):

"Community action agency" means a public agency or a private nonprofit agency which is authorized under its charter or bylaws to receive funds to administer community action programs and is designated by the governor to receive and administer the funds Establishment of community action agencies.

The division shall recognize and assist in the designation of certain community action agencies to assist in the delivery of community action programs. These programs shall include but not be limited to outreach, community services block grant, low-income energy assistance, and weatherization programs. If a community action agency is in effect and currently serving an area, that community action agency shall become the designated community action agency for that area. If any geographic area of the state ceases to be served by a designated community action agency, the division may solicit applications and assist the governor in designating a community action agency for that area in accordance with current community services block grant requirements.

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care providers must be at least 18 years of age.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise
Frequency of Verification:
 Every four years


Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency: 

Provider Type:

Supported Community Living provider

Provider Qualifications

License (specify):

Certificate (specify):

Providers certified under an HCBS waiver for supported community living listed in 441 IAC Chapter 77.

Other Standard (specify):

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist/CBIS or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, supported community living, providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Organizational standards (Outcome 1). Organizational outcome-based standards for HCBS BI providers are as follows:

- a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.
- b. The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.
- c. The organization establishes and maintains fiscal accountability.
- d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.
- e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organization wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

- (5) Identifies areas in need of improvement.
- (6) Develops a plan to address the areas in need of improvement.
- (7) Implements the plan and documents the results.
- g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.
- h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.
- i. The governing body has an active role in the administration of the agency.
- j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type:** Statutory Service**Service Name:** Consumer Directed Attendant Care - Skilled**Provider Category:**

Agency

Provider Type:

Assisted Living Program

Provider Qualifications**License (specify):****Certificate (specify):**

Assisted living programs certified by the department of inspections and appeals 481 IAC Chapter 67

Other Standard (specify):

Initial certification process for a nonaccredited program.

(1) Upon receipt of all completed documentation, including state fire marshal approval and structural and evacuation review approval, the department shall determine whether or not the proposed program meets applicable requirements.

(2) If, based upon the review of the complete application including all required supporting documents, the department determines the proposed program meets the requirements for certification, a provisional certification shall be issued to the program to begin operation and accept tenants.

(3) Within 180 calendar days following issuance of provisional certification, the department shall conduct a monitoring to determine the program's compliance with applicable requirements.

(4) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10

(17A.231B,231C,231D) shall be followed.

(5) The department shall make a final certification decision based on the results of the monitoring and review of an acceptable plan of correction.

(6) The department shall notify the program of a final certification decision within 10 working days following the finalization of the monitoring report or receipt of an acceptable plan of correction, whichever is applicable.

(7) If the decision is to continue certification, the department shall issue a full two-year certification effective from the date of the original provisional certification.

Initial certification process for an accredited program.

(1) Within 20 working days of receiving all finalized documentation, including state fire marshal approval, the department shall determine and notify the accredited program whether or not the accredited program meets applicable requirements and whether or not certification will be issued.

(2) If the decision is to certify, a certification shall be issued for the term of the accreditation not to exceed three years, unless the certification is conditionally issued, suspended or revoked by either the department or the recognized accrediting entity.

(3) If the decision is to deny certification, the department shall provide the applicant an opportunity for hearing in accordance with rule 481—67.13(17A.231B,231C,231D).

(4) Unless conditionally issued, suspended or revoked, certification for a program shall expire at the end of the time period specified on the certificate.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type:** Statutory Service**Service Name:** Consumer Directed Attendant Care - Skilled**Provider Category:**Agency ☒**Provider Type:**

Home Health Agency

Provider Qualifications**License (specify):****Certificate (specify):**

Home Care Agency requirements are listed in 441 IAC Chapter 77.

Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6).

Other Standard (specify):

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care providers must be at least 18 years of age.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type:** Statutory Service**Service Name:** Consumer Directed Attendant Care - Skilled**Provider Category:**Individual ☒**Provider Type:**

Individual

Provider Qualifications**License (specify):**

Certificate (specify):

CDAC Provider Qualifications are listed in 441 IAC Chapter 77

Other Standard (specify):

An individual who contracts with the consumer to provide attendant care service and who is:

- (1) At least 18 years of age.
- (2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
- (3) Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.
- (4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care providers must be at least 18 years of age.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:**

04 Day Services

Sub-Category 1:

04010 prevocational services

Category 2:**Sub-Category 2:**

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Prevocational services" means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially based informed choice regarding the goal of individual employment. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member's local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member, and their family, guardian or legal representative to introduce them to supported employment and explore the member's employment goals and experiences
2. business tours,
3. informational interviews,
4. job shadows,
5. benefits education and financial literacy,
6. assistive technology assessment, and
7. other job exploration events.

Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2. The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.

Setting. Prevocational services shall take place in community-based nonresidential settings.

Concurrent services. A member's individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Exclusions. Prevocational services payment shall not be made for the following:

- (1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.
- (2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- (3) Compensation to members for participating in prevocational services.
- (4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g. hospitals, nursing homes), and support for members volunteering to benefit the service provider is prohibited.
- (5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs

rather than general skills.

(6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

Limitations.

(1) Time limitation for members starting prevocational services. For members starting prevocational services after May 04, 2016, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in Prevocational Services is also working in either individual or small group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or
2. The member who is in Prevocational Services is also working in either individual or small group community employment for less than the number of hours per week the member wants, as identified in the member's current service plan, but the member has services documented in his/her current service plan, or through another identifiable funding source (e.g. IVRS), to increase the number of hours the member is working in either individual or small group community employment; or
3. The member is actively engaged in seeking individual or small group community employment or individual self-employment, and services for this are included in his/her current service plan, or services funded through another identifiable funding source (e.g. IVRS) are documented in the member's service plan; or
4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months and has been denied and/or placed on a waiting list by both Medicaid and IVRS; or
5. The member has been receiving Individual Supported Employment service (or comparable services available through IVRS) for at least 18 months without obtaining seeking individual or small group community employment or individual self-employment.
6. The member is participating in career exploration activities.

Time limitation for members enrolled in prevocational services.

For members enrolled in prevocational services on or before May 4, 2016 participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan. This time limit can be extended as stated in paragraphs "1" through "6." If the criteria in paragraphs "1" through "6" do not apply, the member will not be reauthorized to continue prevocational services.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type/Title
Agency	CARF Accredited Agency
Agency	CQL

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency ☒

Provider Type:

CARF Accredited Agency

Provider Qualifications

License (specify):

Certificate (specify):

79.39(22)

Providers of prevocational services must be accredited by one of the following:

a. The Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.

Other Standard (specify):

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

- (1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.
- (2) A person providing direct support shall not be an immediate family member of the member.
- (3) A person providing direct support shall, within 6 months of hire or within 6 months of May 04, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs.
- (4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Prevocational Services

Provider Category:

Agency ☒

Provider Type:

CQL

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers accredited by the Council on Quality and Leadership

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

- (1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.
- (2) A person providing direct support shall not be an immediate family member of the member.
- (3) A person providing direct support shall, within 6 months of hire or within 6 months of May 04, 2016, complete

at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs.
 (4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa Department of Human Services

Frequency of Verification:

Every Four Years

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:**

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09011 respite, out-of-home

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the member to remain in the member's current living situation.

Respite may be provided in the following locations:

- 1) Member's home
- 2) Member's community
- 3) Adult day care
- 4) Group living foster care facilities for children licensed by the department
- 5) Camps certified by the American Camping Association.
- 6) Nursing facilities.
- 7) Intermediate care facilities for the mentally retarded, and
- 8) Hospitals enrolled as providers in the Iowa Medicaid program.
- 9) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.
- 10) Assisted living programs certified by the department of inspections and appeals.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The following limitations apply:

- a. Services provided outside the member's home shall not be reimbursable if the living unit where the respite is provided is reserved for another person on a temporary leave of absence.
- b. Staff-to-consumer ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes. There is an upper limit set for rates based on provider type that is subject to change on a yearly basis.
- d. The service shall be identified in the member's individual comprehensive plan.
- f. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS B) waiver supported community living services, Medicaid nursing, or Medicaid BI home health aide services.
- g. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the member is attending a camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
- h. "Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.
"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one
"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse."
- i. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- j. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care provided outside of the member's home. This may include Intermediate Care Facilities for persons with Intellectual Disabilities (ICF/ID), residential care facilities for persons with Intellectual Disabilities (RCF/ID), licensed foster care homes, Camps accredited by the American Camping Association, and hotels and motels. Hotels and motels are used based on individual need, the FFP is considered to be included within the rate paid to the respite provider.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Facility - Residential Care Facility
Agency	Camps
Agency	Home Health
Agency	Facility - Nursing Facility
Agency	Child Care Facility
Agency	Facility ICF/ID
Agency	Group Living Foster Care Facility
Agency	Facility - Hospital
Agency	Assisted Living Programs
Agency	Agency
Agency	Adult Day Care
Agency	Home Care Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency **Provider Type:**

Facility - Residential Care Facility

Provider Qualifications**License (specify):**

RCF licensed by the Department of Inspections and Appeals under 481 IAC Chapter 57

Certificate (specify):**Other Standard (specify):**

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public.

Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.


d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type:** Statutory Service**Service Name:** Respite**Provider Category:**Agency **Provider Type:**

Camps

Provider Qualifications**License (specify):****Certificate (specify):**

Camps certified by the American Camping Association. The ACA-Accreditation Program:

- Educates camp owners and directors in the administration of key aspects of camp operation, program quality, and the health and safety of campers and staff.
- Establishes guidelines for needed policies, procedures, and practices for which the camp is responsible for ongoing implementation.
- Assists the public in selecting camps that meet industry-accepted and government recognized standards. ACA's Find a Camp database provides the public with many ways to find the ideal ACA-accredited camp.

Mandatory standards include requirements for staff screening, emergency exits, first aid, aquatic-certified

personnel, storage and use of flammables and firearms, emergency transportation, obtaining appropriate health information, among others.

www.ACAcamps.org/accreditation

Other Standard (specify):

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public.

Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency ☒

Provider Type:

Home Health

Provider Qualifications

License (specify):

Certificate (specify):

441 IAC 77.9 (249A) Home Health Agency certified by Medicare

Other Standard (specify):

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public.

Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian

or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency ☒

Provider Type:

Facility - Nursing Facility

Provider Qualifications

License (specify):

Licensed by the Department of Inspections and Appeals 481 IAC Chapters 58 and 61.

Certificate (specify):

Other Standard (specify):

Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

(1) Procedures for establishing health care facilities as Medicaid facilities. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "State Operations Manual."

a. The facility shall obtain the applicable license from the department of inspections and appeals and must be recommended for certification by the department of inspections and appeals.

b. The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.

c. The Iowa Medicaid enterprise provider services unit shall transmit an application form and a copy of the nursing facility provider manual to the facility.

d. The facility shall complete its portion of the application form and submit it to the Iowa Medicaid enterprise provider services unit.

e. The Iowa Medicaid enterprise provider services unit shall review the application form and verify with the department of inspections and appeals that the facility is licensed and has been recommended for certification.

f. Prior to requesting enrollment, the facility shall contact the department of inspections and appeals to schedule a survey. The department of inspections and appeals shall schedule and complete a survey of the facility.

g. The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.

h. The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division department of inspections and appeals. This plan must be approved before the facility can be certified.

i. The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.

j. When certification is recommended, the department of inspections and appeals shall notify the department recommending a provider agreement.

(2) Medicaid provider agreements. The health care facility shall be recommended for certification by the department of inspections and appeals for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider

agreement may not be earlier than the date of certification.

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public.

Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
 2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
 3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
 4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
- c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.
- d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service Service Name: Respite
Provider Category: Agency <input checked="" type="checkbox"/>
Provider Type: Child Care Facility
Provider Qualifications License (specify): Child Care Facilities that are defined as child care centers, preschools, or child development homes registered pursuant to 441 IAC chapter 110. Certificate (specify): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Standard (specify): Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing. All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name. In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription. Policies shall be developed for: <ol style="list-style-type: none"> 1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification. 2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision. 3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request. 4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or

flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years


Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency 

Provider Type:

Facility ICF/ID

Provider Qualifications

License (specify):

Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) licensed by the Department of Inspections and Appeals 481 IAC Chapters 63 and 64.

Certificate (specify):

Other Standard (specify):

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public.

Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency ☒

Provider Type:

Group Living Foster Care Facility

Provider Qualifications

License (specify):

Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to IAC 441—Chapter 109.

Certificate (specify):

Other Standard (specify):

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public.

Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
 2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
 3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
 4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
- c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.
- d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency ☒

Provider Type:

Facility - Hospital

Provider Qualifications

License (specify):

Licensed by the Department of Inspections and Appeals under 481 Chapter 51

Certificate (specify):

Other Standard (specify):

Enrolled as an Iowa Medicaid provider.

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public.

Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
- c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.
- d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency 

Provider Type:

Assisted Living Programs

Provider Qualifications**License (specify):**

Certificate (specify):

Certified by the Department of Inspections and Appeals Under 481 IAC Chapter 67

Initial certification process for a nonaccredited program.

(1) Upon receipt of all completed documentation, including state fire marshal approval and structural and evacuation review approval, the department shall determine whether or not the proposed program meets applicable requirements.

(2) If, based upon the review of the complete application including all required supporting documents, the department determines the proposed program meets the requirements for certification, a provisional certification shall be issued to the program to begin operation and accept tenants.

(3) Within 180 calendar days following issuance of provisional certification, the department shall conduct a monitoring to determine the program's compliance with applicable requirements.

(4) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10 (17A.231B, 231C, 231D) shall be followed.

(5) The department shall make a final certification decision based on the results of the monitoring and review of an acceptable plan of correction.

(6) The department shall notify the program of a final certification decision within 10 working days following the finalization of the monitoring report or receipt of an acceptable plan of correction, whichever is applicable.

(7) If the decision is to continue certification, the department shall issue a full two-year certification effective from the date of the original provisional certification.

Initial certification process for an accredited program.

(1) Within 20 working days of receiving all finalized documentation, including state fire marshal approval, the department shall determine and notify the accredited program whether or not the accredited program meets applicable requirements and whether or not certification will be issued.

(2) If the decision is to certify, a certification shall be issued for the term of the accreditation not to exceed three years, unless the certification is conditionally issued, suspended or revoked by either the department or the recognized accrediting entity.

(3) If the decision is to deny certification, the department shall provide the applicant an opportunity for hearing in accordance with rule 481—67.13(17A,231B,231C,231D).

(4) Unless conditionally issued, suspended or revoked, certification for a program shall expire at the end of the time period specified on the certificate

Other Standard (specify):

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public.

Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency 

Provider Type:

Agency

Provider Qualifications

License (specify):

Certificate (specify):

Agencies certified by the department to provide respite in a member's home that meet the organizational standards set forth in 441 IAC 77.39(1), 77.39(3) through 77.39(7)

Other Standard (specify):

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's

directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public.

Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
 2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
 3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
 4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
- c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.
- d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency ☒

Provider Type:

Adult Day Care

Provider Qualifications

License (specify):

Certificate (specify):

Certified by the Department of Inspections and Appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321 - Chapter 24.

Other Standard (specify):

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public.

Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
 2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
 3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
 4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
- c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.
- d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary

team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years


Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency 

Provider Type:

Home Care Agency

Provider Qualifications

License (specify):

Certificate (specify):

Home care agencies that meet the Home Care requirements set forth in IAC 641-80.5(135), 641-80.6 (135) and 641-80.7 (135) or certified by Medicare as a Home Health agency

Other Standard (specify):

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public.

Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
- c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.
- d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:**

03 Supported Employment

Sub-Category 1:

03010 job development

Category 2:

03 Supported Employment

Sub-Category 2:

03021 ongoing supported employment, individual

Category 3:

03 Supported Employment

Sub-Category 3:

03022 ongoing supported employment, group

Category 4:

03 Supported Employment

Sub-Category 4:

03030 career planning

Service Definition (Scope):

Individual supported employment. Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

Scope. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

Expected outcome of service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education
2. Career exploration (e.g., tours, informational interviews, job shadows).
3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).

11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13. Re-employment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on the job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.

Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10)"a"(4), assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.
2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
3. Identification of the long-term supports necessary for the individual to operate the business.

Long-term job coaching. Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member's personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

Setting. Long-term job coaching services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in service provider's organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider's organization were the provider not being paid to provide the job coaching to the member.

Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized and service plan are adjusted as support needs change. may include any combination of the following activities with or on behalf of the member:

1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
4. Engagement of natural supports.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
9. Financial literacy and asset development.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).
12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.
13. Transportation of the member during service hours.
14. Career exploration services leading to increased hour or career advancement.

Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27 (10)"b"(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;
2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
3. Ongoing benefits education and support.

The hours of support tier assignment for long-term job coaching is based on the identified needs of the member as documented in the member's comprehensive service plan and adjusted when higher support needs are determined.

Small-group supported employment. Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Scope. Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration, or development of strengths and skills that contribute to successful participation in individual community employment.

Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member's residence.

Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.
2. Person-centered employment planning.
3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
4. Job analysis.
5. On-the-job training and systematic instruction.
6. Job coaching.
7. Transportation planning and training.
8. Benefits education.
9. Career exploration services leading to career advancement outcomes.
10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.
11. Transportation of the member during service hours.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service for Individual Supported Employment is 15 minutes

A unit of service for Small Group Employment is 15 minutes

A unit of service for Long-Term Job Coaching is a monthly unit of service. The hours of support tier assignment for long-term job coaching is based on the identified needs of the member as documented in the member's comprehensive service plan and adjusted when higher support needs are determined based on the hours of support the member requires each month.

Service requirements for all supported employment

- (1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.
- (2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.
- (3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.
- (4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).
- (5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or

members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(6) Compensation: Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

Limitations. Supported employment services are limited as follows:

- (1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.
- (2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed \$3,029.00 per month.
- (3) Individual supported employment is limited to 240 units per calendar year.
- (4) Long-term job coaching is limited in accordance with 44)—subrule 79.1(2).

Exclusions. Supported employment services payments shall not be made for the following:

- (1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.
- (2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.
- (3) Subsidies or payments that are passed through to users of supported employment programs.
- (4) Training that is not directly related to a member's supported employment program.
- (5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.
- (6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.
- (7) Tuition for education or vocational training.
- (8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.
- (9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

For member's choosing the Consumer Choices Option, the individual budget limit will be based on the member's authorized service plan and the need for the services available to be converted to the CCO budget.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☒ Legally Responsible Person
- ☒ Relative
- ☒ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF
Agency	JCAHO
Agency	CAFC
Agency	ICCB
Agency	CQL

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:Agency ☒**Provider Type:**

CARF

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

- (1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.
- (2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.
- (3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 04, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
- (4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The Department of Human Services

Frequency of Verification:

Every Four Years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:Agency ☒**Provider Type:**

JCAHO

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

- (1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.
- (2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.
- (3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 04, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
- (4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services

Frequency of Verification:

Every Four Years


Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:

Agency 

Provider Type:

CAPC

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

- (1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.
- (2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.
- (3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
- (4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services

Frequency of Verification:

Every Four Years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:

Agency ☐

Provider Type:

ICCD

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

An agency that is accredited by the International Center for Clubhouse Development.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

Individuals may not provide supported employment services except when the services are purchased through the

consumer choices option

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.

(2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.

(3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 04, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services

Frequency of Verification:

Every Four Years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

CQL

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.

(2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.

(3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 04, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:


Every four years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:


Extended State Plan Service 

Service Title:


Specialized Medical Equipment

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications 

Sub-Category 1:

14031 equipment and technology 

Category 2:



Sub-Category 2:



Category 3:



Sub-Category 3:



Category 4:



Sub-Category 4:



Service Definition (Scope):

Specialized Medical Equipment shall include medically necessary items for personal use by the member with a brain injury which provide for the health and safety of the member which are not ordinarily covered by Medicaid, and are not funded by educational or vocational rehabilitation programs, and are not provided on a voluntary means. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture design and installation. This includes but is not limited to : electronic aids and organizaers, electronic medication dispensing devices, communication devices, bath aids, and noncovered environmental control units. This includes repair and maintenace of items purchased through the waiver in addition to initial purchase cost.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Members may receive specialized medical equipment once per month until a maximum yearly usage of \$6,366.64 per year has been reached. The yearly usage dollar amount is subject to change on an annual basis. The upper rate limits are published in 441 IAC Chapter 79.

A unit of service is one occurrence.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Retail and Wholesale businesses
Agency	Medical Equipment and Supply dealers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
 Service Name: Specialized Medical Equipment

Provider Category:

Agency 

Provider Type:

Retail and Wholesale businesses

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Enrolled a providers in the Medicaid program. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Upon enrollment and every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
 Service Name: Specialized Medical Equipment

Provider Category:

Agency 

Provider Type:

Medical Equipment and Supply dealers

Provider Qualifications

License (specify):

Certificate (specify):

441—77.10(249A) All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

Other Standard (specify):

Enrolled as a provider in the Medicaid program

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case Managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Upon enrollment and every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction ☒

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services ☒

Alternate Service Title (if any):

Financial Management Service - Supports the self-direction option

HCBS Taxonomy:

Category 1:

12 Services Supporting Self-Direction ☒

Sub-Category 1:

12010 financial management services in support of self-direction ☒

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

The Financial Management Service (FMS) is necessary for all members choosing the self-direction option, and is available only to those who self direct. The FMS is enrolled as a Medicaid Provider. The FMS will receive Medicaid funds in an electronic transfer and will pay all service providers and employees electing the self-direction option. The FMS services are provided to ensure that the individualized budgets are managed and distributed according to the budget developed by each member and to facilitate the employment of service workers. For those members who self-direct, the FMS will:

- Establish and manage members and directly hired workers documents and files
- Manage and monitor timesheets and invoices to assure that they match the written budget
- Provide monthly and quarterly status reports for the Department and for the member that include a summary of expenditures paid and amounts of budgets that are unused.
- Assist members in understanding their fiscal/payroll related responsibilities
- Assist members in completing required federal, state and local tax and insurance forms
- Assist members in conducting criminal background checks on potential employees, if requested
- Assist members in verifying service workers citizenship or alien status

- Prepares and disburses payroll if a program member hires workers. Key employer-related tasks include:
- Verifying that service workers' hourly wages are in compliance with federal and state Department of Labor rules;
- Collecting and processing services workers' timesheets;
- Withholding, filing and paying federal, state and local income, Medicare and Social Security (FICA), federal (FUTA) and state (SUTA) unemployment and disability insurance (as applicable) taxes;
- Computing and processing other benefits, as applicable;
- Preparing and issuing service workers' payroll checks;
- Refunding over collected FICA, when appropriate (Fiscal/Employer Agent)
- Refunding over collected FUTA, when appropriate (Fiscal/Employer Agent)
- Processing all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws, and
- Prepare and disburse IRS Forms W-2 and W-3 annually.
- Process and pay invoices for approved goods and services included in program members' budgets.
- Assists in implementing the state's quality management strategy related to FMS
- Establish an accessible customer service system and communication path for the member and the Individual Support Broker
- Provide monthly statements of Individual Budget account balances to both the Individual Support Broker and the member
- Provide real time Individual Budget account balances, at a minimum during normal business hours (9-5, Monday –Friday)
- Ability to interface with the tracking system chosen by the Iowa Department of Human Services

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The monthly fee for financial management services is subject to an upper limit which is subject to change on a yearly basis.

A member who elects the consumer choices option may purchase the following services and supports, which shall be provided in the member's home or at an integrated community setting:

- (1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community.
- (2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration.
- (3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address a need identified in the member's service plan. The item or service shall decrease the member's need for other Medicaid services, promote the member's inclusion in the community, or increase the member's safety in the community.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☒ Legally Responsible Person
- ☒ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Financial Management Service - Supports the self-direction option

Provider Category:

Agency ☒

Provider Type:

Financial Management Service

Provider Qualifications

License (specify):

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Certificate (specify):

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Other Standard (specify):

The Financial Management Service must meet the criteria under 441 IAC Chapter 77.

Financial Institution that meets the following qualifications.

a. The financial institution shall either:

- (1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or
- (2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Programming

HCBS Taxonomy:**Category 1:**

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10040 behavior support

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Behavioral Programming consists of individually designed strategies to increase the member's appropriate behaviors and decrease the member's maladaptive behaviors, which have interfered with the members ability to remain in the community. Behavioral programming consists of:

1. A complete assessment of both appropriate and maladaptive behaviors
2. Development of a structured behavioral intervention plan which should be identified in the Individual Treatment Plan.
3. Implementation of the behavioral intervention plan.
4. On-going training and supervision to caregivers and behavioral aides.
5. Periodic reassessment of the plan, but no less than quarterly.

Types of appropriate behavioral programming include but are not limited to : clinical redirection, token economies, reinforcement, extinction, modeling and over-learning.

Token economies reinforce desired behavior with a tangible reinforcement of the person's preference. Clinical redirection includes verbal redirection or talking to the person to redirect their attention away from the targeted behavior or physical redirection by leading or guiding the person to a different environment. reinforcement may be verbal praise, a tangible object

or preferred activity of the member. Extinction occurs when reinforcement of a previously reinforced behavior is discontinued. Modeling occurs when the person learns from watching someone else perform the desired behavior. Over Learning occurs when the person continues to practice newly acquired skills past the level of skill mastery. The behavioral intervention plan goal must be identified in the member's comprehensive service plan or treatment plan. The behavioral programs developed must be developed using evidenced based practices and may not include any experimental approaches to behavioral support.

Behavioral programming may occur in the member's home or community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is 15 minutes. There is an upper rate limit for this service which is subject to change on a yearly basis.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Aide Provider
Agency	Hospice Provider
Agency	Mental Health Center
Agency	Brain Injury Waiver Providers
Agency	Mental Health Service Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Behavioral Programming

Provider Category:

Agency

Provider Type:

Home Health Aide Provider

Provider Qualifications

License (specify):

Certificate (specify):

Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

Other Standard (specify):

Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury.

In addition, they must meet the following requirements.

- Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441- 83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81 (249A) and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services. The Iowa Medicaid Enterprise

Frequency of Verification:


Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:

Agency 

Provider Type:

Hospice Provider

Provider Qualifications

License (specify):

Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53

Certificate (specify):

Agencies which are certified to meet the standards under the Medicare program for hospice programs.

Other Standard (specify):

Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury.

In addition, they must meet the following requirements.

- a. Behavior assessment and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441-83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81 (249A) and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services, The Iowa Medicaid Enterprise

Frequency of Verification:


Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:

Agency 

Provider Type:

Mental Health Center

Provider Qualifications

License (specify):

Certificate (specify):

Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—IAC Chapter 24

Other Standard (specify):

Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

- (1) Staffing shall: Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—35.1(225C.230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio. Reflect how program continuity will be provided. Reflect an interdisciplinary team of professionals and

paraprofessionals include a designated director who is a mental health professional as defined in rule 441—33.1 (225C.230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C.230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; post discharge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury.

In addition, they must meet the following requirements.

a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441- 83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81 (249A) and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Behavioral Programming

Provider Category:

Agency ☒

Provider Type:

Brain Injury Waiver Providers

Provider Qualifications

License (specify):

--

Certificate (specify):

Providers enrolled to deliver HCBS BI Waiver services in accordance with 441 IAC Chapter 77.39

Other Standard (specify):

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist

(CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, supported community living, providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Organizational standards (Outcome 1). Organizational outcome-based standards for HCBS BI providers are as follows:

- a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.
- b. The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.
- c. The organization establishes and maintains fiscal accountability.
- d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.
- e. The organization provides needed training and supports to its staff. This training includes at a minimum:
 - (1) Consumer rights.
 - (2) Confidentiality.
 - (3) Provision of consumer medication.
 - (4) Identification and reporting of child and dependent adult abuse.
 - (5) Individual consumer support needs.
- f. The organization has a systematic, organization wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:
 - (1) Measures and assesses organizational activities and services annually.
 - (2) Gathers information from consumers, family members, and staff.
 - (3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).
 - (4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.
 - (5) Identifies areas in need of improvement.
 - (6) Develops a plan to address the areas in need of improvement.
 - (7) Implements the plan and documents the results.
- g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.
- h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.
- i. The governing body has an active role in the administration of the agency.
- j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury.

In addition, they must meet the following requirements.

- a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441- 83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81 (249A) and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services, The Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Behavioral Programming

Provider Category:

Agency ☒

Provider Type:

Mental Health Service Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

Mental health service provider" means an organization whose services are established to specifically address mental health services to individuals or the administration of facilities in which these services are provided.

Organizations included are:

1. Those contracting with a county board of supervisors to provide mental health services in lieu of that county's affiliation with a community mental health center (Iowa Code chapter 230A).
2. Those that may contract with a county board of supervisors for special services to the general public or special segments of the general public and that are not accredited by any other accrediting body.

These standards do not apply to individual practitioners or partnerships of practitioners covered under Iowa's professional licensure laws.

Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury.

In addition, they must meet the following requirements.

- a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441- 83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81 (249A) and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services, The Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Attendant Care (CDAC) unskilled

HCBS Taxonomy:**Category 1:**

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Consumer-directed attendant care may occur in the member's home or community.

The service activities may include helping the member with any of the following nonskilled service activities:

- (1) Dressing.
- (2) Bath, shampoo, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.
- (4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.
- (5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.
- (6) Housekeeping services which are essential to the member's health care at home.
- (7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.
- (8) Wound care.
- (9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Cognitive assistance with tasks such as handling money and scheduling.
- (11) Fostering communication through interpreting and reading services as well as assistive devices for communication.
- (12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of services is 15 minutes. Services are billed in whole units. There are upper rate limits which are subject to change on a yearly basis.

The first line of prevention of duplicative billing for similar types of services, such as home health aide, is the member's case manager. The case manager is responsible for the authorization and monitoring of services in a member's plan of care. If the case manager authorizes similar services, they are responsible to assure that the services are being delivered as ordered. The ISIS system generates a review report to assist the case manager. The report identifies all services that have been billed for a specific time period (ex. one month). The case manager is able to view the service billed to the individual member, the amount of the service billed and the provider. The case manager is able to compare what has been billed by the provider to what is ordered in the plan of care. The department also conducts post audit reviews of providers to review the billing of providers to assure that the services provided have documentation to support the billing.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☒ Legally Responsible Person
☒ Relative
☒ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care provider
Agency	Community Action Agency
Agency	Home Health Agency
Agency	Chore provider
Agency	Home Care provider
Agency	Assisted Living provider
Individual	Individual
Agency	Supported Community Living Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:

Agency

Provider Type:

Adult Day Care provider

Provider Qualifications

License (specify):

Certificate (specify):

Adult day care providers that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Service Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled
Provider Category:
Agency
Provider Type:
Community Action Agency
Provider Qualifications
License (specify):
Certificate (specify):
Other Standard (specify):
<p>Community action agencies as designated in Iowa Code section 216A.93:</p> <p>"Community action agency" means a public agency or a private nonprofit agency which is authorized under its charter or bylaws to receive funds to administer community action programs and is designated by the governor to receive and administer the funds Establishment of community action agencies.</p> <p>The division shall recognize and assist in the designation of certain community action agencies to assist in the delivery of community action programs. These programs shall include but not be limited to outreach, community services block grant, low-income energy assistance, and weatherization programs. If a community action agency is in effect and currently serving an area, that community action agency shall become the designated community action agency for that area. If any geographic area of the state ceases to be served by a designated community action agency, the division may solicit applications and assist the governor in designating a community action agency for that area in accordance with current community services block grant requirements.</p> <p>Providers shall be eligible to participate in the Medicaid brain injury waiver program, if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care providers must be at least 18 years of age.</p>
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Human Services
Frequency of Verification:
Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled
Provider Category:
Agency
Provider Type:
Home Health Agency

Provider Qualifications**License (specify):**

Certificate (specify):

44) — 77.9(249A) Home health agencies. Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6)

Other Standard (specify):

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the sub rules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under sub rule 77.39(11). Consumer-directed attendant care providers must be at least 18 years of age."

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa DHS - Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Consumer Directed Attendant Care (CDAC) unskilled****Provider Category:**Agency ☒**Provider Type:**

Chore provider

Provider Qualifications**License (specify):**

Certificate (specify):

441 IAC 77.33(7)Chore providers

a. Home health agencies certified under Medicare.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.

f. Community businesses that are engaged in the provision of chore services and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage

Other Standard (specify):

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must

have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care providers must be at least 18 years of age.

Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging. Providers must be:

1. At least 18 years of age, and
2. Qualified or trained to carry out the member's plan of care pursuant to the department's approved plan.
3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
5. All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. A provider may be disenrolled if an individual is convicted of any criminal activity or has a founded abuse record.

For this service the department the specific standards for subcontracts or providers regarding training, age limitations, experience or education are indicated above. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case Managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:

Agency ☒

Provider Type:

Home Care provider

Provider Qualifications

License (specify):

Certificate (specify):

Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135)

Other Standard (specify):

Standards

The authorized agency shall ensure that each individual assigned to perform home care aide services meets one of the following:

- (1) Be an individual who has completed orientation to home care in accordance with agency policy. At a minimum, orientation shall include four hours on the role of the home care aide; two hours on communication; two hours on understanding basic human needs; two hours on maintaining a healthy environment; two hours on infection control in the home; and one hour on emergency procedures. The individual shall have successfully passed an agency written test and demonstrated the ability to perform skills for the assigned tasks; or

- (2) Be an individual who is in the process of receiving education or has completed the educational requirements but is not licensed as an LPN or RN, has documentation of successful completion of coursework related to the tasks to be assigned, and has demonstrated the ability to perform the skills for the assigned tasks; or
- (3) Be an individual who possesses a license to practice nursing as an LPN or RN in the state of Iowa; or
- (4) Be an individual who is in the process of receiving education or who possesses a degree in social work, sociology, family and consumer science, education, or other health and human services field; has documentation of successful completion of coursework related to the tasks to be assigned; and has demonstrated the ability to perform the skills for the assigned tasks.
- b. The authorized agency shall ensure that services or tasks assigned are appropriate to the individual's prior education and training.
- c. The authorized agency shall ensure documentation of each home care aide's completion of at least 12 hours of annual in-service (prorated to employment).
- d. The authorized agency shall establish policies for supervision of home care aides.
- e. The authorized agency shall maintain records for each consumer. The records shall include:
- (1) An initial assessment;
 - (2) A plan of care;
 - (3) Assignment of home care aide;
 - (4) Assignment of tasks;
 - (5) Reassessment;
 - (6) An update of the plan of care;
 - (7) Home care aide documentation; and
 - (8) Documentation of supervision of home care aides.

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care providers must be at least 18 years of age.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa DHS- Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:

Agency ☒

Provider Type:

Assisted Living provider

Provider Qualifications

License (specify):

Certificate (specify):

Assisted living programs certified by the department of inspections and appeals 481 IAC Chapter 67
Initial certification process for a nonaccredited program.

- (1) Upon receipt of all completed documentation, including state fire marshal approval and structural and evacuation review approval, the department shall determine whether or not the proposed program meets applicable requirements.
- (2) If, based upon the review of the complete application including all required supporting documents, the department determines the proposed program meets the requirements for certification, a provisional certification shall be issued to the program to begin operation and accept tenants.
- (3) Within 180 calendar days following issuance of provisional certification, the department shall conduct a monitoring to determine the program's compliance with applicable requirements.
- (4) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10 (17A.231B, 231C, 231D) shall be followed.
- (5) The department shall make a final certification decision based on the results of the monitoring and review of an acceptable plan of correction.
- (6) The department shall notify the program of a final certification decision within 10 working days following the finalization of the monitoring report or receipt of an acceptable plan of correction, whichever is applicable.
- (7) If the decision is to continue certification, the department shall issue a full two-year certification effective from the date of the original provisional certification.

Initial certification process for an accredited program.

- (1) Within 20 working days of receiving all finalized documentation, including state fire marshal approval, the department shall determine and notify the accredited program whether or not the accredited program meets applicable requirements and whether or not certification will be issued.
- (2) If the decision is to certify, a certification shall be issued for the term of the accreditation not to exceed three years, unless the certification is conditionally issued, suspended or revoked by either the department or the recognized accrediting entity.
- (3) If the decision is to deny certification, the department shall provide the applicant an opportunity for hearing in accordance with rule 481—67.13(17A.231B, 231C, 231D).
- (4) Unless conditionally issued, suspended or revoked, certification for a program shall expire at the end of the time period specified on the certificate

Other Standard (specify):

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care providers must be at least 18 years of age.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:

Individual ☒

Provider Type:

Individual

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

An individual who contracts with the consumer to provide attendant care service and who is:

- (1) At least 18 years of age.
- (2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
- (3) Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.
- (4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa DSH - Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:

Agency ☒

Provider Type:

Supported Community Living Provider

Provider Qualifications

License (specify):

Certificate (specify):

Providers certified under an HCBS waiver for supported community living.

Supported Community Living Provider requirements are listed in 441 IAC Chapter 77.

Other Standard (specify):

Supported Community Living Provider requirements are listed in 441 IAC Chapter 77.

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, supported community living, providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Organizational standards (Outcome 1). Organizational outcome-based standards for HCBS BI providers are as follows:

- a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.
- b. The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.
- c. The organization establishes and maintains fiscal accountability.
- d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.
- e. The organization provides needed training and supports to its staff. This training includes at a minimum:
 - (1) Consumer rights.
 - (2) Confidentiality.
 - (3) Provision of consumer medication.
 - (4) Identification and reporting of child and dependent adult abuse.
 - (5) Individual consumer support needs.
- f. The organization has a systematic, organization wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:
 - (1) Measures and assesses organizational activities and services annually.
 - (2) Gathers information from consumers, family members, and staff.
 - (3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).
 - (4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.
 - (5) Identifies areas in need of improvement.
 - (6) Develops a plan to address the areas in need of improvement.
 - (7) Implements the plan and documents the results.
- g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.
- h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441-----Chapters 175 and 176.
- i. The governing body has an active role in the administration of the agency.
- j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care providers must be at least 18 years of age.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ☒

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Counseling and Training Services

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services ✓

Sub-Category 1:

10060 counseling ✓

Category 2:

✓

Sub-Category 2:

✓

Category 3:

✓

Sub-Category 3:

✓

Category 4:

✓

Sub-Category 4:

✓

Service Definition (Scope):

Family counseling and training services are face-to-face mental health services provided to the member and the family with whom the member lives (or who routinely provides care to the member) to increase the member's or family members' capabilities to maintain and care for the member in the community.

Family counseling and training may be provided by:

- ◆ Community mental health centers
- ◆ Hospices (licensed or certified under Medicare)
- ◆ Accredited mental health service providers
- ◆ Qualified brain injury professionals

"Family" may include spouse, children, friends, or in-laws of the member. It does not include people who are employed to care for the member.

Counseling may include the use of treatment regimens as specified in the individual treatment plan. Periodic training updates may be necessary to safely maintain the member in the community.

Counseling may include helping the member or family members with:

- ◆ Crisis
- ◆ Coping strategies
- ◆ Stress reduction
- ◆ Management of depression
- ◆ Alleviation of psychosocial isolation
- ◆ Support in coping with the effects of a brain injury

Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of a qualified provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is one 15 minute increment. There is an upper rate limit that is subject to change on a yearly basis.

Payment for group counseling is based on a group rate divided by six or the actual number of members participating in the group if the number of participants exceeds six members.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative

☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Mental Health Centers
Individual	Qualified Brain Injury Professional
Agency	Mental Health Service Provider
Individual	Hospice Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Family Counseling and Training Services

Provider Category:

Agency ☐

Provider Type:

Community Mental Health Centers

Provider Qualifications

License (specify):

Certificate (specify):

Providers certified as Community Mental Health Centers established by the MH/DD commission set forth in 441 IAC Chapter 24, Divisions I and II, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441-83.81(249A)

Other Standard (specify):

Providers for the services set forth in sub rules 24.4(9) through 24.4(13) shall meet the standards in sub rules 24.4(1) through 24.4(8) in addition to the standards for the specific service. Providers of outpatient psychotherapy and counseling services shall also meet standards in sub rules 24.4(1), 24.4(2), 24.4(4), 24.4(6), 24.4(7), and 24.4(8).

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Family Counseling and Training Services

Provider Category:

Individual ☐

Provider Type:

Qualified Brain Injury Professional

Provider Qualifications

License (specify):

Certificate (specify):

Meet the definition of qualified brain injury professional as set forth in rule IAC 441-83.81 (249A)

Other Standard (specify):

"Qualified brain injury professional" means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years' experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in psychology, sociology, or public health or rehabilitation services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
 Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Counseling and Training Services
Provider Category:
Agency <input type="checkbox"/>
Provider Type:
Mental Health Service Provider
Provider Qualifications
License (specify):
<div style="border: 1px solid black; height: 20px;"></div>
Certificate (specify):
Providers for the services set forth in subrules 24.4(9) through 24.4(13) shall meet the standards in subrules 24.4(1) through 24.4(8) in addition to the standards for the specific service. Providers of outpatient psychotherapy and counseling services shall also meet standards in subrules 24.4(1), 24.4(2), 24.4(4), 24.4(6), 24.4(7), and 24.4(8).
Other Standard (specify):
Mental health service provider" means an organization whose services are established to specifically address mental health services to individuals or the administration of facilities in which these services are provided.
Organizations included are:
1. Those contracting with a county board of supervisors to provide mental health services in lieu of that county's affiliation with a community mental health center (Iowa Code chapter 230A).
2. Those that may contract with a county board of supervisors for special services to the general public or special segments of the general public and that are not accredited by any other accrediting body.
These standards do not apply to individual practitioners or partnerships of practitioners covered under Iowa's professional licensure laws."

Providers for the services set forth in sub rules 24.4(9) through 24.4(13) shall meet the standards in sub rules 24.4(1) through 24.4(8) in addition to the standards for the specific service. Providers of outpatient psychotherapy and counseling services shall also meet standards in sub rules 24.4(1), 24.4(2), 24.4(4), 24.4(6), 24.4(7), and 24.4(8)."

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11).


Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type:** Other Service**Service Name:** Family Counseling and Training Services**Provider Category:**Individual **Provider Type:**

Hospice Provider

Provider Qualifications**License (specify):**

Providers licensed and meeting the hospice standards and requirements set forth in the Department of Inspection and Appeals rules IAC 481- chapter 53

Certificate (specify):

Providers certified to meet the standards under Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441 83.81(249A)

Other Standard (specify):

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11).

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Service Specification**


State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home and Vehicle Modification

HCBS Taxonomy:**Category 1:**14 Equipment, Technology, and Modifications **Sub-Category 1:**14020 home and/or vehicle accessibility adaptations **Category 2:****Sub-Category 2:**

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Covered home and vehicle modifications are those physical modifications to the member's home or vehicle listed below that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded. Purchase or lease of a vehicle and regularly scheduled upkeep and maintenance of a vehicle are excluded. Repairs include any action that is intended to restore to a good or sound condition after decay or damage. Manufacturer recommended upkeep and routine maintenance of the modifications are included.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There is an annual limit established for this service which is subject to change on a yearly basis.

Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the member.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services covered under durable medical equipment or specialized medical equipment.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency
Agency	Community Business
Agency	Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home and Vehicle Modification

Provider Category:

Agency ☒

Provider Type:

Agency

Provider Qualifications

License (specify):

Certificate (specify):

Providers meeting the requirements of 441 IAC Chapter 77.

Other Standard (specify):

Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver

"For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case Managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner."

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home and Vehicle Modification

Provider Category:

Agency ☒

Provider Type:

Community Business

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

447 IAC 77.39(16)Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case Managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home and Vehicle Modification

Provider Category:

Agency

Provider Type:

Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

"For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case Managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner."

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §446.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Independent Support Broker - Consumer Choices Option

HCBS Taxonomy:

Category 1:

12 Services Supporting Self-Direction



Sub-Category 1:

12020 information and assistance in support of self-direction

Category 2:



Sub-Category 2:



Category 3:



Sub-Category 3:



Category 4:



Sub-Category 4:



Service Definition (Scope):

Independent Support Brokerage service is necessary for all members who chose the self-direction option. This is a service that is included in the member's Budget. The Independent Support Brokerage will be chosen and hired by the member. The ISB will work with the member to guide them through the person centered planning process and offer technical assistance and expertise for selecting and hiring employees and/or providers and purchasing supports.

The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is necessary for members who choose the self-direction option at a maximum of 26 hours a year. When a member first initiates the self-direction option, the Independent Support Broker will be required to meet with the member at least monthly for the first three months and quarterly after that. If a member needs additional support brokerage service, the member will need prior authorization from the state. There will be a maximum rate per hour limit.

A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan. The Case Manager oversees the services authorized to develop the monthly CCO budget. Independent Support Broker must document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the

member's individual budget has addressed the member's needs and the satisfaction of the member. The Case Manager, the Financial Management Service and the department may review this documentation at any time.

Service Delivery Method (*check each that applies*):

- ☒ Participant-directed as specified in Appendix E
☐ Provider managed

Specify whether the service may be provided by (*check each that applies*):

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Support Broker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Independent Support Broker - Consumer Choices Option

Provider Category:

Individual ✓

Provider Type:

Individual Support Broker

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications.

- The broker must be at least 18 years of age.
- The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.
- The broker shall not provide any other paid service to the member.
- The broker shall not work for an individual or entity that is providing services to the member.
- The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.
- The broker must complete independent support brokerage training approved by the department.
- The broker will not work for an individual or entity that is providing services to the member.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services- Iowa Medicaid Enterprise

Frequency of Verification:

Once initially trained, the Individual Support Broker is placed on a Independent Support Brokerage registry that is maintained at the Iowa Department of Human Services Iowa Medicaid Enterprise. The Independent Support Broker will be responsible for attending one support broker training a year held at the HCBS regional meetings

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Interim Medical Monitoring and Treatment (IMMT)

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11010 health monitoring

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
- (4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
- (5) The member-to-staff ratio shall not be more than six members to one staff person.
- (6) The parent or guardian of the member shall be responsible for the usual and customary

nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A maximum of 48 15 min units are available per day. There is an upper rate limit for the service which is subject to change on a yearly basis.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type/Title
Agency	Supported Community Living provider
Agency	Home Health Agency
Agency	Child Care Facility

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Interim Medical Monitoring and Treatment (IMMT)

Provider Category:

Agency ☒

Provider Type:

Supported Community Living provider

Provider Qualifications

License (specify):

Certificate (specify):

Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

Other Standard (specify):

Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

- 1) Be at least 18 years of age, and
- 2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under, and
- 3) Not be a usual caregiver of the member, and
- 4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Interim Medical Monitoring and Treatment (IMMT)

Provider Category:

Agency ☒

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Certificate (specify):

441—77.9(249A) Home Health agencies certified to participate in the Medicare program.

Other Standard (specify):

Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

- 1) Be at least 18 years of age, and
- 2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under, and
- 3) Not be a usual caregiver of the member, and
- 4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Interim Medical Monitoring and Treatment (IMMT)

Provider Category:

Agency ☒

Provider Type:

Child Care Facility

Provider Qualifications

License (specify):

Certificate (specify):

Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

Other Standard (specify):

Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

- 1) Be at least 18 years of age, and
- 2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under, and
- 3) Not be a usual caregiver of the member, and
- 4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-I/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:Other Service ☒

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System or Portable Locator System

HCBS Taxonomy:**Category 1:**14 Equipment, Technology, and Modifications ☒**Sub-Category 1:**14010 personal emergency response system (PERS) ☒**Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency. The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability. The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

Provider staff are responsible for training members regarding the use of the system; the cost of this service is included in the charges for installation or monthly fee, depending upon how the provider structures their fee schedule. If necessary, case managers would also assist members in understanding how to utilize the system.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is a one time installation fee or month of service. Maximum units per state fiscal year shall be one initial installation and 12 months of service. The member's plan of care will address how the member's health care needs are met. Services must be authorized in the service plan. The Case Manager will monitor the plan.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type/Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Personal Emergency Response System or Portable Locator System

Provider Category:

Agency ☒

Provider Type:

Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ☒

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Self Directed Community Support and Employment

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's service worker. Services may include self-directed payment for social skills development, career placement, vocational planning, and independent daily living activity skill development. The outcome of this service is to maintain integrated living in the community or to sustain paid employment at or above the State's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities in an integrated setting in the general workforce, and in a job that meets personal and career goals. Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or 2) payments that are passed through to users of supported employment services.

Transportation may be covered for members from their place of residence and the employment site as a component of this service and the cost may be included in the rate.

The following are examples of supports a member can purchase to help the member live and work in the community:

- o Career counseling
- o Career preparation skills development
- o Cleaning skills development
- o Cooking skills development
- o Grooming skills development
- o Job hunting and career placement
- o Personal and home skills development
- o Safety and emergency preparedness skills development
- o Self-direction and self-advocacy skills development
- o Social skills development training
- o Supports to attend social activities
- o Supports to maintain a job
- o Time and money management
- o Training on use of medical equipment
- o Utilization of public transportation skills development
- o Work place personal assistance

Participants (or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Participants or their guardians must review all time cards to ensure accuracy and work with their case manager and ISB to budget services. If a participant is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community support and employment services must be identified on the individual budget plan. The individual budget limit will be based on the member's authorized service plan and the need for the services available to be converted to the CCO budget. Services that may be included in determining the individual budget amount for a member in the

HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Specialized medical equipment.
7. Supported community living.
8. Supported employment.
9. Transportation

A utilization adjustment rate is applied to the individual budget amount. Please see Section E- 2- b ii for details on how the QCO budget is created. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
☐ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☒ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or Businesses

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Self Directed Community Support and Employment

Provider Category:

Individual ☒

Provider Type:

Individual or Businesses

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

All persons providing these services must be at least 18 years of age. All persons must be able to demonstrate to the member the ability to successfully communicate with the member. Individuals and businesses providing services and supports shall have all the necessary licenses required by federal, state and local laws and regulations

The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

The member, the Independent Support Broker and the Financial Management Service.

Frequency of Verification:

Every four years. The member retains the employer authority.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ☒

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Self Directed Goods and Services

HCBS Taxonomy:

Category 1:

17 Other Services ☒

Sub-Category 1:

17010 goods and services ☒

Category 2:

☐

Sub-Category 2:

☐

Category 3:

☐

Sub-Category 3:

☐

Category 4:

☐

Sub-Category 4:

☐

Service Definition (Scope):

Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

Participants (or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Participants or their guardians must review all time cards to ensure accuracy and work with their case manager and ISB to budget services. If a participant is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Individual directed goods and services must be documented on the individual budget. The individual budget limit will be based on the service plan and the need for the services available to be converted. A utilization adjustment rate is applied to the individual budget amount. Please see Section E- 2- b ii for details on how the CCO budget is created.

The following goods and services may not be purchased using a self-directed budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
- ☐ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☒ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or Businesses

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Self Directed Goods and Services

Provider Category:

Individual ☒

Provider Type:

Individual or Businesses

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

All persons providing these services must be at least 18 years of age. All persons must be able to demonstrate to the member the ability to perform the task or tasks hire to perform. All persons hired must have the availability to

successfully communicate with the member. Individuals and businesses providing services and supports shall have all the necessary licenses required by federal state and local laws and regulations

The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities

Verification of Provider Qualifications

Entity Responsible for Verification:

The member, the independent support broker and the financial management service

Frequency of Verification:


Every four years. The member retains the employer authority

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Self Directed Personal Care - Consumer Choices Option

HCBS Taxonomy:

Category 1:

08 Home-Based Services 

Sub-Category 1:

08030 personal care 

Category 2:



Sub-Category 2:



Category 3:



Sub-Category 3:



Category 4:



Sub-Category 4:



Service Definition (Scope):

Self-directed personal care services are services and/or goods that provide a range of assistance in the member's home or community that they would normally do themselves if they did not have a disability: activities of daily living and incidental activities of daily living that help the person remaining the home and in their community. This assistance may take the form of hands-on assistance (actually performing a task for a person) or cuing to prompt the participant to perform a task. Personal care may be provided on an episodic or on a continuing basis.

Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by State law. These services are only available for those that self-direct. The member will have budget authority over self-directed personal care services. The dollar amount available for this service will be based on the needs identified on the service plan. Overlapping of services is avoided by the use of a case manager who manages all services and the entry into the ISIS system. The case manager and interdisciplinary team determine which service is necessary and authorize transportation for both HCBS and self-directed services.

Participants (or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Participants or their guardians must review all time cards to ensure accuracy and work with their case manager and ISB to budget services. If a participant is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Self-directed personal care services need to be identified on the individual budget plan. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan. The Case Manager oversees the services authorized to develop the monthly CCO budget as well as traditional services accessed.

Transportation costs within this service is billed separately and not included in the scope of personal care. Please see Section E-2- b ii. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
☐ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☒ Relative
☒ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or Business

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Self Directed Personal Care - Consumer Choices Option

Provider Category:

Individual 

Provider Type:

Individual or Business

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

All persons providing these services must be at least 16 years of age. All persons must be able to demonstrate to the consumer the ability to successfully communicate with the consumer. Individuals and businesses providing services shall have all the necessary licenses required by federal, state and local laws and regulations. The consumer and the independent support broker are responsible for determining provider qualifications for the individual employees identified on the individual budget.

Response: The following was added to the other standards section: The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may

perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

The member and the Independent Support Broker and the Financial Management Service.

Frequency of Verification:

Every four years, the member retains the employer authority

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ☒

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supported Community Living

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services ☒

Sub-Category 1:

02011 group living, residential habilitation ☒

Category 2:

02 Round-the-Clock Services ☒

Sub-Category 2:

02023 shared living, other ☒

Category 3:

02 Round-the-Clock Services ☒

Sub-Category 3:

02031 in-home residential habilitation ☒

Category 4:

☒

Sub-Category 4:

☒

Service Definition (Scope):

Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services. definitions of the components are as follows:

Personal and home skills training services are those activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

Individual advocacy services" means the act or process of representing the individual's rights and interests in order to realize the rights to which the individual is entitled and to remove barriers to meeting the individual's needs.

Community skills training services means activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget; plan and prepare nutritional meals; ability to use community resources such as public transportation, libraries, etc., and ability to select foods at the grocery store.
2. Socialization skills training services are those activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.
3. Communication skills training services are activities which assist a person to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

Personal and environmental support services means activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

Transportation services means activities and expenditures designed to assist the person to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from medical services. Members needing transportation to and from medical services must use the state plan medical transportation services.

Treatment services means activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.
2. Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person's functioning in response to the physical, emotional, and social environment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is:

- (1) One full calendar day when a member residing in the living unit receives on-site staff supervision for 8 or more hours per day as an average over a 7-day week and the member's individual comprehensive plan or case plan identifies and reflects the need for this amount of supervision. The cost per unit is capped at the average ICF/ID rate calculated retrospectively each year. If the member's needs exceed the upper rate limit allowed in rule . Members may request an exception to policy to exceed the upper rate limit. allowed in administrative rule.
- (2) 15 minute units when subparagraph (1) does not apply. 15 minute unit reimbursement amounts cannot exceed the fee schedule caps published in the Iowa Administrative Code 441 - 77.79(1).

For daily unit reimbursement, the provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The cost of transportation may be included in the rate of the services as allowed by rule. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures.

The maximum number of units available per member is as follows:

- (1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.
 - (2) 20,440 15 minute units are available per state fiscal year except a leap year when 20,496 15 minute units are available.
- h. The service shall be identified in the member's individual comprehensive plan.
- i. Services shall not be simultaneously reimbursed with other residential services, HCBS respite, Medicaid nursing, or Medicaid or HCBS home health aide services.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Supported Community Living

Provider Category:

Agency

Provider Type:

Provider

Provider Qualifications

License (specify):

Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

Certificate (specify):

Providers shall meet the outcome-based standards set forth in subrules IAC 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1)

Other Standard (specify):

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, supported community living, providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Organizational standards (Outcome 1). Organizational outcome-based standards for HCBS BI providers are as follows:

- The organization demonstrates the provision and oversight of high-quality supports and services to consumers.
- The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.
- The organization establishes and maintains fiscal accountability.
- The organization has qualified staff commensurate with the needs of the consumers they serve.

These staff demonstrate competency in performing duties and in all interactions with clients.

The organization provides needed training and supports to its staff. This training includes at a minimum:

- (1) Consumer rights.
- (2) Confidentiality.
- (3) Provision of consumer medication.
- (4) Identification and reporting of child and dependent adult abuse.
- (5) Individual consumer support needs.

f. The organization has a systematic, organization wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

- (1) Measures and assesses organizational activities and services annually.
- (2) Gathers information from consumers, family members, and staff.
- (3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

- (4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.
- (5) Identifies areas in need of improvement.
- (6) Develops a plan to address the areas in need of improvement.
- (7) Implements the plan and documents the results.
- g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.
- h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.
- i. The governing body has an active role in the administration of the agency.
- j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:**Category 1:**15 Non-Medical Transportation **Sub-Category 1:**15010 non-medical transportation **Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.

This service does not include transportation to Medicaid covered medical services which is provided under the state plan covered benefit called Non Emergency Medical Transportation (NEMT).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is either per mile, per trip. Transportation may not be reimbursed simultaneously with any other transportation service and may not be duplicative of any transportation service provided under the State plan.

Transportation shall not be reimbursed simultaneously with supported community living services when the SCL rate paid to

provider includes the cost of member's transportation.
There is an upper rate limit that is subject to change on a yearly basis.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Regional Transit Agency
Agency	Nursing Facilities
Agency	Community Action Agency
Agency	Area Agency on Aging
Agency	Non-Emergency Medical Transportation Provider contracted with the NEMT Broker
Agency	Transportation Provider
Agency	HCBS Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Regional Transit Agency

Provider Qualifications

License (specify):

Certificate (specify):

As designated by the Iowa Department of Transportation in the Code of Iowa 28M.

Other Standard (specify):

77.37(24) Transportation service providers. The following providers may provide transportation:

- Accredited providers of home- and community-based services.
- Regional transit agencies as recognized by the Iowa department of transportation.
- Transportation providers that contract with county governments.
- Community action agencies as designated in Iowa Code section 216A.93.
- Nursing facilities licensed under Iowa Code chapter 135C.
- Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
- Transportation providers contracting with the nonemergency medical transportation contractor.

28M.1 Regional transit district defined

"Regional transit district" means a public transit district created by agreement pursuant to chapter 28E by one or more counties and participating cities to provide support for transportation of passengers by one or more public transit systems which may be designated as a public transit system under chapter 324A.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education beyond those implemented by the contracting agency or provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
 Every four years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
 Service Name: Transportation

Provider Category:

Agency 

Provider Type:

Nursing Facilities

Provider Qualifications

License (specify):

Nursing facilities are licensed by the Department of Inspections and Appeals under 481 IAC Chapters 58. and 61.

Certificate (specify):

Other Standard (specify):

77.37(24) Transportation service providers. The following providers may provide transportation:

- Accredited providers of home- and community-based services.
- Regional transit agencies as recognized by the Iowa department of transportation.
- Transportation providers that contract with county governments.
- Community action agencies as designated in Iowa Code section 216A.93.
- Nursing facilities licensed under Iowa Code chapter 135C.
- Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
- Transportation providers contracting with the nonemergency medical transportation contractor.

Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

(1) Procedures for establishing health care facilities as Medicaid facilities. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "State Operations Manual."

- The facility shall obtain the applicable license from the department of inspections and appeals and must be recommended for certification by the department of inspections and appeals.
- The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.
- The Iowa Medicaid enterprise provider services unit shall transmit an application form and a copy of the nursing facility provider manual to the facility.
- The facility shall complete its portion of the application form and submit it to the Iowa Medicaid enterprise provider services unit.
- The Iowa Medicaid enterprise provider services unit shall review the application form and verify with the department of inspections and appeals that the facility is licensed and has been recommended for certification.
- Prior to requesting enrollment, the facility shall contact the department of inspections and appeals to schedule a survey. The department of inspections and appeals shall schedule and complete a survey of the facility.
- The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.
- The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division department of inspections and appeals. This plan must be approved before the facility can be certified.
- The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.
- When certification is recommended, the department of inspections and appeals shall notify the department recommending a provider agreement.

(2) Medicaid provider agreements. The health care facility shall be recommended for certification by the department of inspections and appeals for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider

agreement may not be earlier than the date of certification

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public.

Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency ☒

Provider Type:

Community Action Agency

Provider Qualifications

License (specify):

Certificate (specify):

Community action agencies as designated in Iowa Code section 216A.93.

Other Standard (specify):

77.37(24) Transportation service providers. The following providers may provide transportation:

- a. Accredited providers of home- and community-based services.
- b. Regional transit agencies as recognized by the Iowa department of transportation.
- c. Transportation providers that contract with county governments.
- d. Community action agencies as designated in Iowa Code section 216A.93.
- e. Nursing facilities licensed under Iowa Code chapter 135C.
- f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
- g. Transportation providers contracting with the nonemergency medical transportation contractor.

"Community action agency" means a public agency or a private nonprofit agency which is authorized under its charter or bylaws to receive funds to administer community action programs and is designated by the governor to receive and administer the funds Establishment of community action agencies.

The division shall recognize and assist in the designation of certain community action agencies to assist in the delivery of community action programs. These programs shall include but not be limited to outreach, community

services block grant, low-income energy assistance, and weatherization programs. If a community action agency is in effect and currently serving an area, that community action agency shall become the designated community action agency for that area. If any geographic area of the state ceases to be served by a designated community action agency, the division may solicit applications and assist the governor in designating a community action agency for that area in accordance with current community services block grant requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency

Provider Type:

Area Agency on Aging

Provider Qualifications

License (specify):

Certificate (specify):

Area agencies on aging as designated in 17 IAC —4.4(231): Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and Iowa Code chapter 231. An area agency on aging shall be any one of the following:

- a. An established office of aging operating within a planning and service area;
- b. Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an area agency on aging by the chief elected official of such unit;
- c. Any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for such purpose;
- d. Any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such agency, which for designation purposes is under the supervision or direction of the department and which can and will engage only in the planning or provision of a broad range of supportive services or nutrition services within such planning and service area; or
- e. Any other entity authorized by the Older Americans Act.

or

2) with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

Other Standard (specify):

77.37(24) Transportation service providers. The following providers may provide transportation:

- a. Accredited providers of home- and community-based services.
- b. Regional transit agencies as recognized by the Iowa department of transportation.
- c. Transportation providers that contract with county governments.
- d. Community action agencies as designated in Iowa Code section 216A.93.
- e. Nursing facilities licensed under Iowa Code chapter 135C.
- f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
- g. Transportation providers contracting with the nonemergency medical transportation contractor.

Area agencies on aging as designated in 321—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:


Every four years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency 

Provider Type:

Non-Emergency Medical Transportation Provider contracted with the NEMT Broker

Provider Qualifications

License (specify):

Certificate (specify):

441 IAC 77.39(18)

Other Standard (specify):

77.37(24) Transportation service providers. The following providers may provide transportation:

- Accredited providers of home- and community-based services.
- Regional transit agencies as recognized by the Iowa department of transportation.
- Transportation providers that contract with county governments.
- Community action agencies as designated in Iowa Code section 216A.93.
- Nursing facilities licensed under Iowa Code chapter 135C.
- Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
- Transportation providers contracting with the nonemergency medical transportation contractor.

Request for Proposal for Contract Award: The Broker will utilize Public Transit agencies, private transportation agencies and individuals. The network of providers may also include other transportation alternatives, such as the services of volunteers, taxis, wheelchair vans, stretcher vans, ambulances, and air ambulances (fixed wing and rotary). All transportation is to be provided with an occupant protection system that addresses the safety needs of the disabled or special needs individuals.

The Broker will be required to ensure that all eligible Medicaid Members receive transportation services that are safe, reliable and on time by providers who are licensed, qualified, competent, and courteous.

The Department's Contract Administrator for the IME is the principal contact with the transportation Broker. The Department's Contract Administrator is responsible for monitor the contract performance and compliance with contract terms and conditions.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Medicaid Enterprise, Provider Services contractor

Frequency of Verification:


Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency 

Provider Type:

Transportation Provider

Provider Qualifications

License (specify):

Certificate (specify):

441-IA 77.39(18)

Other Standard (specify):

Transportation service providers. The following providers may provide transportation:

- a. Accredited providers of home- and community-based services.
- b. Regional transit agencies as recognized by the Iowa department of transportation.
- c. Transportation providers that contract with county governments.
- d. Community action agencies as designated in Iowa Code section 216A.93.
- e. Nursing facilities licensed under Iowa Code chapter 135C.
- f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
- g. Transportation providers contracting with the nonemergency medical transportation contractor.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education beyond those implemented by the contracting agency. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa medicaid Enterprise

Frequency of Verification:

Every four years.


Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency 

Provider Type:

HCBS Provider Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Certified or Accredited enrolled HCBS providers under 441 IAC Chapter 24 and/ or Chapter 77

Other Standard (specify):

77.37(24) Transportation service providers. The following providers may provide transportation:

- a. Accredited providers of home- and community-based services.
- b. Regional transit agencies as recognized by the Iowa department of transportation.
- c. Transportation providers that contract with county governments.
- d. Community action agencies as designated in Iowa Code section 216A.93.
- e. Nursing facilities licensed under Iowa Code chapter 135C.
- f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
- g. Transportation providers contracting with the nonemergency medical transportation contractor.

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-

directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, supported community living, providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Organizational standards (Outcome 1). Organizational outcome-based standards for HCBS BI providers are as follows:

- a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.
- b. The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.
- c. The organization establishes and maintains fiscal accountability.
- d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.
- e. The organization provides needed training and supports to its staff. This training includes at a minimum:
 - (1) Consumer rights.
 - (2) Confidentiality.
 - (3) Provision of consumer medication.
 - (4) Identification and reporting of child and dependent adult abuse.
 - (5) Individual consumer support needs.
- f. The organization has a systematic, organization wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:
 - (1) Measures and assesses organizational activities and services annually.
 - (2) Gathers information from consumers, family members, and staff.
 - (3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).
 - (4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.
 - (5) Identifies areas in need of improvement.
 - (6) Develops a plan to address the areas in need of improvement.
 - (7) Implements the plan and documents the results.
- g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.
- h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.
- i. The governing body has an active role in the administration of the agency.
- j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

- b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

☐ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

☒ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☒ As a waiver service defined in Appendix C-3. Do not complete item C-1-c.

☐ As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.

☒ As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.

☐ As an administrative activity. Complete item C-1-c.

- c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

FFS

Case managers or integrated health home coordinators provide case management services for members enrolled in the State's §1915 (c) PD waiver. Services are reimbursed through an administrative function of DHS.

All individuals providing case management services have knowledge of community alternatives for the target populations and the full range of long-term care resources, as well as specialized knowledge of the conditions and functional limitations of the target populations served, and of the individual members to whom they are assigned.

MCO

MCO community-based case managers provide case management services to all members receiving HCBS. MCOs ensure ease of access and responsiveness for each member to their community-based case manager during regular business hours and, at a minimum, the community-based case manager contacts members at least monthly, either in person or by phone, with an interval of at least fourteen calendar days between contacts.

MCO community-based case managers or integrated health home care coordinators provide case management services to all members receiving HCBS. MCOs ensure ease of access and responsiveness for each member to their community-based case manager during regular business hours and, at a minimum, the community-based case manager or integrated health home care coordinator contacts members at least monthly, either in person or by phone, with an interval of at least fourteen calendar days between contacts.

All individuals providing case management services have knowledge of community alternatives for the target populations and the full range of long-term care resources, as well as specialized knowledge of the conditions and functional limitations of the target populations served, and of the individual members to whom they are assigned. MCOs are contractually required to ensure the delivery of services in a conflict free manner consistent with Balancing Incentive Program requirements. DHS approves and monitors all MCO policies and procedures to ensure compliance.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ☐ No. Criminal history and/or background investigations are not required.
- ☒ Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Pursuant to Iowa Code 135C.33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a participant:

1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

Iowa Code 249A.29 provides the scope of the above provider background screening:

1. For purposes of this section and section 249A.30 unless the context otherwise requires:
 - a. "Consumer" means an individual approved by the department to receive services under a waiver.
 - b. "Provider" means an agency certified by the department to provide services under a waiver.
 - c. "Waiver" means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
2. If a person is being considered by a provider for employment involving direct responsibility for a consumer (individual approved by the department to receive services under a waiver) or with access to a consumer when the consumer is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department (Department of Human Services) shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position

sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.

4. If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

As part of the provider's self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the criminal background checks. The provider agency is responsible for completing the required waiver to perform the criminal background check and submitting to the Department of Public Safety who conducts the check. The data and other information developed by the provider in the areas of discovery, remediation, and improvement of criminal background checks are available to the Department upon request. The IME will assure that criminal background checks have been completed through quality improvement activities on a random sampling of providers, focused onsite reviews and during the full on-site reviews conducted every 5 years.

The State HCBS Quality Assurance and Technical Assistance Unit reviews agency personnel records during provider site visits to ensure screenings have been completed. Screenings are rerun anytime there is a complaint related to additional criminal charges against a provider, and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis. DHS also completes any evaluation needed for screenings returned with records or charges. Background checks only include Iowa unless the applicant is a resident of another state providing services in Iowa.

MCOs are contractually required to assure that all persons, whether they are employees, agents, subcontractors, or anyone acting for or on behalf of the MCO, are properly licensed, certified, or accredited as required under applicable state law and the Iowa Administrative Code. The Contractor shall provide standards for service providers who are not otherwise licensed, certified, or accredited under state law or the Iowa Administrative Code.

- b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ☐ No. The State does not conduct abuse registry screening.
- ☒ Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Pursuant to Iowa Code 135C.33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a participant:

1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

Iowa Code 249A.29 provides the scope of the above provider background screening:

1. For purposes of this section and section 249A.30 unless the context otherwise requires:
 - a. "Consumer" means an individual approved by the department to receive services under a waiver.
 - b. "Provider" means an agency certified by the department to provide services under a waiver.
 - c. "Waiver" means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
2. If a person is being considered by a provider for employment involving direct responsibility for a consumer (individual approved by the department to receive services under a waiver) or with access to a consumer when the consumer is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a

person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.

4. If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

Individual Consumer Directed Attendant Care (CDAC) is the only service that allows individuals to be providers. All other services must be provided by agency providers. Individual CDAC providers have child and dependent adult abuse background checks completed by the IME Provider Services prior to enrollment as a Medicaid provider.

All employees that provide direct services under the Consumer Choices Option under this waiver are required to complete child and dependent adult abuse background checks prior to employment with a member. The Fiscal Management provider completes the child and dependent adult abuse background checks and the employee will not pay for any services to the member prior to the completion of the checks.

The Iowa Department of Human Services maintains the Central Abuse Registry. All child and dependent adult abuse checks are conducted by the DHS unit responsible for the intake, investigation, and finding of child and dependent adult abuse. The provider agency is responsible for completing the required abuse screening form and submitting it to DHS to conduct the screening. Providers are required to complete the child and dependent adult abuse background checks of all staff that provides direct services to waiver members prior to employment. Providers are required to have written policies and procedures for the screening of personnel for child and dependent adult abuse checks prior to employment. As part of the provider's self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the child and dependent adult abuse checks. The data and other information developed by the provider in the areas of discovery, remediation, and improvement of child and dependent adult abuse checks are available to the Department upon request. The Department will assure that the child and dependent adult abuse checks have been completed through the Department's quality improvement activities of random sampling of providers, focused onsite reviews, initial certification and periodic reviews and during the full on-site reviews conducted every 5 years.

The State HCBS Quality Assurance and Technical Assistance Unit reviews agency personnel records during provider site visits to ensure screenings have been completed. Screenings are rerun anytime there is a complaint related to additional criminal charges against a provider, and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis. DHS also completes any evaluation needed for screenings returned with records or charges. MCOs are also required to ensure that all required screening is conducted for providers who are not employees of a provider agency or licensed/accredited by a board that conducts background checks (i.e., non-agency affiliated self-direction service providers). DHS retains final authority to determine if an employee may work in a particular program.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ☒ No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.
- ☐ Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- ☒ No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
- ☐ Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in

the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- ☐ Self-directed
- ☐ Agency-operated

- e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in item C-2-d. *Select one:*

- ☐ The State does not make payment to relatives/legal guardians for furnishing waiver services.
- ☒ The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

A member's relative or legal guardian may provide services to a member. Payments may be made to any relative who is not the parent of a minor child, a spouse, or a legal representative of the member. Legal representative means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger. The relative or legal guardian may be an Individual CDAC provider, a participant under the CCO program, or an employee hired by a provider agency. There are no limitations on the types of services provided, however, when the relative or legal guardian is the CDAC or CCO provider, the case manager, health home coordinator, or community-based case manager, and interdisciplinary team determine the need for and the types of activities provided by the relative or legal guardian. If the relative or legal guardian is an employee of a provider agency, it is the responsibility of the provider to assure the relative or legal guardian has the skills needed to provide the services to the member.

Whenever a legal representative acts as a provider of consumer-directed attendant care, the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the participant's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event. In many situations, the participant requests the guardian provide services, as the guardian knows the participant and their needs best. In other circumstances, there are no other qualified providers available when the service is needed or a lack of staff in the area to provide the service.

The rate of pay and the care provided by the legally responsible person is identified and authorized in the member's service plan that is authorized and monitored by the member's case manager, health home coordinator, or community-based case manager.

DHS TCM, health home coordinators, and community-based case managers are responsible to monitor service plans and assure the services authorized in the member's plan are received. In addition, information on paid claims of fee-for-service members is available in ISIS for review. The ISIS System compares the submitted claim to the services authorized in the service plan prior to payment. The claim will not be paid if there is a discrepancy between the amount billed or the rate of pay authorized in the plan. The state also completes post utilization audits on waiver providers verifying that services rendered match the service plan and claim process. This applies to individual CDAC providers and provider agencies. MCOs are required to adhere to all state policies, procedures and regulations regarding payment to legal guardians, as outlined in this section.

Per to 441 Iowa Administrative Code 79.9(7):

"a. Except as provided in paragraph 79.9(7)"b," medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7)"a," medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013.

For purposes of this paragraph, "legal representative" means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger."

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

- f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Iowa Medicaid providers will be responsible for providing services to fee-for-service members. The Iowa Medicaid Provider Services Department markets provider enrollment for Iowa Medicaid. Potential providers may access an application on line through the website or by calling the provider services' phone number. The IME Provider Services Unit must respond in writing within five working days once a provider enrollment application is received, and must either accept the enrollment application and approve the provider as a Medicaid provider or request more information. In addition, waiver quality assurance staff and waiver program managers, as well as county and State service workers, case managers, health home coordinators, market to qualified providers to enroll in Medicaid.

MCOs are responsible for oversight of their provider networks. For the first two years of an MCO contract, the entity must give all 1915(c) HCBS waiver providers, which are currently enrolled as Iowa Medicaid providers, the opportunity to be part of its provider network. During this time period, the MCO may recommend disenrollment of providers not meeting defined performance measures. The State retains authority for development of the performance standards, and for review and approval of any disenrollment recommendations.

After the 2-year initial period of the MCO contract, the State ensures that LTSS providers are given the opportunity for continued participation in the managed care networks by regularly monitoring the managed care organization provider network and evaluating rationales for not having providers in their networks. While the number of providers not contracted with all three managed care organizations is small, the rationale includes providers not accepting the "floor" rates determined by the State and wanting enhanced rates. The State additionally tracks on provider inquiries and complaints which includes complaints related to network access and credentialing.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. *Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each

source of data is analyzed statistically/deductively or inductively; how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

QP-a1: The IME will measure the number and percent of licensed or certification waiver provider enrollment applications verified against the appropriate licensing and/or certification entity. Numerator = # and percent of waiver providers verified against appropriate licensing and/or certification entity prior to providing services. Denominator = # of licensed or certified waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Encounter data, claims data and enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by the IME PS.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Contracted entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):

- b. *Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.*

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

QP-b1: The IME shall determine the number and percent of CDAC providers that met waiver requirements prior to direct service delivery. Numerator = # of CDAC providers who met waiver requirements prior to service delivery; Denominator = # of CDAC enrolled providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Encounter data, claims data and enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by the IME PS.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contract entity	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- c. *Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.*

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively; how themes are identified or conclusions drawn; and how recommendations are formulated, where appropriate.

Performance Measure:

QP-cl: The IME will measure the total number and percent of providers, specific by waiver, that meet training requirements as outlined in State regulations. Numerator = # of reviewed HCBS providers which did not have a corrective action plan issued related to training; Denominator = # of HCBS waiver providers that had a certification or periodic quality assurance review.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Provider's evidence of staff training and provider training policies. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: Contracted	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>

	<input type="checkbox"/> Other Specify:	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The IME Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment. All MCO providers must be enrolled as verified by IME Provider Services.

The Home and Community Based Services (HCBS) quality oversight unit is responsible for reviewing provider records at a 100% level over a three to five year cycle, depending on certification or accreditation. If it is discovered that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated if noncompliance persists.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

If it is discovered by Provider Services Unit during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, the provider is required to correct deficiency prior to enrollment or reenrollment approval. Until the provider make these corrections, they are ineligible to provide services to waiver members. All MCO providers must be enrolled as verified by IME Provider Services, so if the provider is no longer enrolled by the IME then that provider is no longer eligible to enroll with an MCO.

If it is discovered during HCBS Quality Oversight Unit review that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated if noncompliance persists.

General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and required changes in individual provider policy.

ii. Remediation Data Aggregation**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: contracted entity and MCO	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- ☒ No
☐ Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

- a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ☒ **Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
☐ **Applicable -** The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- ☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- ☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

Other Type of Limit. The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Detailed information and timelines for the HCBS Settings project are included in Attachment #2 HCB Settings. The Iowa Medicaid Enterprise received initial CMS approval for Iowa's statewide HCBS transition plan on August 10, 2016.